Appendix 7

Wisconsin Medicaid Adjustment Request Form (for photocopying)

WMAP ADJUSTMENT REQUEST FORM

1. PROVIDER NAME _____

2. PROVIDER NUMBER | | | | | | | | |

DO NOT WRITE IN THIS SPACE

3. R&S DATE _____

5. RECIPIENT NAME _____

4. CLAIM NUMBER | | | | | | | | | | | | | | |

6. RECIPIENT NUMBER | | | | | | | | | | |

☐ ADD NEW DETAIL(S) TO PREVIOUSLY PAID/ALLOWED CLAIM: (In 7-15, enter information to be added)

☐ CORRECT DETAIL ON PREVIOUSLY PAID/ALLOWED CLAIM: (In 7-15, enter information as it appears on R&S report)

7. DATE(S) OF SERVICE FROM	TO	8. POS	9. TOS	10. PROCEDURE/ NDC/REVENUE CODE MOD MOD	11. BILLED AMT	12. UNIT QTY	13. EPSDT FAM PLAN	14. EMG	15. PERFORMING PROVIDER

16. REASON FOR ADJUSTMENT

☐ RECOUP ENTIRE MA PAYMENT

☐ OTHER INSURANCE PAYMENT $ _____ (OI-P)

☐ COPAY DEDUCTED IN ERROR: ☐ RECIPIENT IN NURSING HOME ☐ COVERED DAYS _____ ☐ EMERGENCY

☐ MEDICARE RECONSIDERATION (EOMB's ATTACHED)

☐ CORRECT DETAIL (In 7-15, enter information as it appears on R&S report. Enter correct information in comment area)

☐ OTHER/COMMENTS:

17. SIGNATURE

18. DATE

INSTRUCTIONS: (SEE REVERSE SIDE FOR FURTHER INSTRUCTIONS)

MAIL TO: EDS
6406 BRIDGE ROAD
MADISON, WI 53784-0002

19. ☐ CLAIM FORM ATTACHED (OPTIONAL)